Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **New York** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Care At Home I/II

C. Waiver Number: NY.4125
Original Base Waiver Number: NY.4125.

D. Amendment Number: NY.4125.R04.01

E. Proposed Effective Date: *(mm/dd/yy)*

04/15/09

Approved Effective Date: 04/15/09
Approved Effective Date of Waiver being Amended: 04/15/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
To change the wording and citation to add a SSI eligibility group for children.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	B-4

☐ **Appendix C – Participant Services**	
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☐ **Appendix J – Cost-Neutrality Demonstration**	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☑ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **New York** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Care At Home I/II

C. Type of Request: amendment

Original Base Waiver Number: NY.4125
Waiver Number: NY.4125.R04.01
Draft ID: NY.19.04.01

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 12/01/08
Approved Effective Date of Waiver being Amended: 04/15/09

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- ☑ **Hospital**

Select applicable level of care

■ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

■ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

■ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

■ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

■ **Not applicable**

■ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The CAH I/II waiver serves children under age eighteen who are determined physically disabled and require a nursing facility or hospital level of care. The purpose of the waiver is to avoid unnecessary institutionalization for eligible children by providing appropriate access to MA State Plan and waiver services.

The waiver renewal application reflects recent amendments to CAH I/II statutory authorization, New York State Social Services Law, Section 366(6). There are two significant programmatic changes: adjustment to the financial eligibility criteria to allow MA eligible children to participate in the waiver, and the addition of five new pediatric palliative care services: Family Palliative Care Education, Pain and Symptom Management, Bereavement Services, Massage Therapy, and Expressive Therapies.

Other administrative changes include: elimination of the eligibility requirement for a thirty day prior hospitalization, the shift from an individual to an aggregate service expenditure cap, and elimination of the limit on the number of waiver participants at any one time in order to accommodate the broader group of MA children who will be participating in the waiver.

CAH I/II is operated statewide. The New York State Department of Health (NYSDOH), as the Single State Medicaid Agency, administers and provides oversight of the waiver program. In New York State (NYS), the 62 Local Departments of Social Services (LDSS) are charged with implementing the Medicaid program including the daily operations and administrative functions of the CAH I/II waiver.

The roles and responsibilities of the LDSS are established by the State Public Health Law, Sections 201 and 206, Social Services Law Sections 363-a and 366.6, and by the Medicaid State Plan, Appendix A, # 4. In addition, NYS bulletins, specifically General Information System (GIS) and Medicaid Administrative Directives (ADM), are issued and updated as needed to provide ongoing guidance regarding Medicaid program administration, including eligibility determination, system management, provider reimbursement, monitoring and corrective actions.

Service delivery is arranged by the CAH I/II case manager in accordance with the participant's Plan of Care developed in conjunction with the child's family/legal guardian and physician. The plan identifies the waiver and State Plan services necessary to maintain the waiver participant safely in the home community. All CAH I/II services are delivered by NYSDOH enrolled MA providers, the exception being that home/vehicle modifications are delivered through LDSS approved contractors and craftsmen.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to

participants who direct their services. (*Select one*):

- ■ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ■ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ■ **Not Applicable**
- ■ **No**
- ■ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ■ **No**
- ■ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- ☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the

Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
In January 2007, NYSDOH surveyed all families who had a child enrolled in the CAH waivers during 2006. The survey provided them an opportunity to comment on their experience as a user of the waiver services and to make recommendations for program improvement. In addition, NYSDOH waiver management staff work closely with advocacy groups for families of children with disabilities and waiver service providers. Such groups include: the Coalition for Medically Fragile Children and the Hospice and Palliative Care Association of New York State that actively participated in the development of the new palliative care waiver services included for the first time in this renewal application.

Pursuant to Presidential Executive Order #13175, NYSDOH provided the State's nine federally recognized Tribal Governments with written notification of the CAH I/II waiver renewal application and all proposed substantial changes to the program and offered an opportunity for their comment.

NYSDOH is a statutorily required member of the State's Most Integrated Setting Coordinating Council (MISCC), established by Chapter 551 of the Laws of 2002 and responsible for developing and implementing a comprehensive Statewide plan to ensure that people of all ages with physical and mental disabilities receive care and services in the most integrated settings appropriate to their individual needs. State agencies are responsible for implementation of applicable sections of the plan. Open to the public and broadcast on the State's website, the MISCC quarterly meetings provide an excellent opportunity to inform and encourage public input concerning ongoing efforts to rebalance the State's long term care (LTC) Medicaid system, including improvements to MA services for children.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Maloney
First Name:	Colleen
Title:	MA Specialist II
Agency:	New York State Department of Health, Office of Long Term Care
Address:	One Commerce Plaza, Suite 826
Address 2:	
City:	Albany
State:	**New York**
Zip:	12260
Phone:	(518) 486-6562 **Ext:** ☐ **TTY**
Fax:	(518) 473-2537
E-mail:	cam09@health.state.ny.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	
First Name:	
Title:	
Agency:	
Address:	
Address 2:	
City:	
State:	**New York**
Zip:	
Phone:	**Ext:** **TTY**
Fax:	
E-mail:	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Deborah Bachrach
	State Medicaid Director or Designee
Submission Date:	Sep 15, 2009

Last Name:	Bachrach
First Name:	Deborah
Title:	Deputy Commissioner, Medicaid Director
Agency:	Office of Health Insurance Programs, NYS Department of Health
Address:	Empire State Plaza, Corning Tower
Address 2:	Room 1466
City:	Albany
State:	**New York**
Zip:	12237
Phone:	(518) 474-0318
Fax:	(518) 486-6852

E-mail: dsb10@health.state.ny.us

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

■ **The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

■ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

■ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
Office of Long Term care
(Complete item A-2-a).

■ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   The New York State Department of Health (NYSDOH) is designated as the Single State Agency responsible for the administration of the Medicaid (MA) program.

   The Deputy Commissioner of the NYSDOH Office of Health Insurance Programs (OHIP), is the Director of the MA program and, in that capacity, is the signatory of the Care At Home I/II (CAH I/II) waiver application. The Deputy Commissioner of the NYSDOH Office of Long Term Care (OLTC) is responsible for policy and administration of all long term care programs, including CAH I/II and other long term care 1915(c) MA waivers.

   These two offices, OHIP and OLTC, collaborate in accordance with the recognized NYSDOH organizational structure on the administration of MA long term care programs. However, the State Medicaid Director has final authority with regard to administration of all aspects of the MA program, including its waiver programs.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ■ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   ■ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ■ **Not applicable**

■ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☑ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

In New State (NYS), the Local Departments of Social Services (LDSS) are charged with implementing the MA program including the CAH I/II waiver. Responsibilities of the LDSS include the on-going review of participant level of care assessment; participation in the development of and review of the comprehensive home assessment resulting in a proposed Plan of Care; and authorization of participation in the waiver for enrollees.

The respective roles and responsibilities of the State and the LDSS are established by the State Public Health Law Sections 201 and 206, Social Services Law Section 363-a and 366(6), and by the MA State Plan (Appendix A, #4) specific to CAH I/II. In addition, NYS bulletins, General Information System (GIS), and MA Administrative Directives (ADM) are issued and updated as needed to provide ongoing guidance regarding MA program administration, including eligibility determination, system management, provider reimbursement, monitoring, and corrective action. Accordingly, no additional Memorandum of Understanding between the State and an LDSS is necessary.

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The NYSDOH OLTC Division of Home and Community Based Services (DHCBS) is the unit responsible for the day-to-day operation and oversight of the CAH I/II waiver program and is, accordingly, responsible for assessing the performance of the LDSS waiver administration in their respective counties.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
NYSDOH waiver management staff oversee and monitor the administration of the CAH I/II waiver through annual case record reviews designed to assess the LDSS' understanding of its role, responsibilities, and waiver administrative processes.

The LDSS is required to track and submit quarterly reports regarding participant applications, including the number of authorized participants, disenrolled participants, and applicants denied waiver participation. These reports and

records are also used to assess LDSS waiver administrative performance.

NYSDOH waiver management staff participate in a variety of activities in order to maintain an open line of communication with the LDSSs for the provision of technical assistance and complaint investigations. For example, quarterly conference call meetings with the LDSSs statewide provide opportunities for information updates and discussion of issues to ensure consistency in policy interpretation and implementation. Minutes of the meetings are sent to LDSS CAH I/II coordinators. NYSDOH waiver management staff participate in training and other meetings organized by Consortia, an association of regional MA administrative stakeholders. The Consortia meetings encourage discussion of common issues and interests in a face-to-face environment. All such venues provide an opportunity for administrative activities assessment, feedback, and development of corrective activities concerning CAH I/II waiver services.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Local Non-State Entity
Participant waiver enrollment	☑	☑
Waiver enrollment managed against approved limits	☑	☑
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑
Qualified provider enrollment	☑	☐
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☐	☐
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
   i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of case files, retrospectively reviewed each year by NYSDOH waiver management staff, that required remediation and were referred to the LDSS CAH I/II Coordinator.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% Random Sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of LDSS quarterly reports of program activity submitted for review and approval to NYSDOH.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of quarterly conference calls held to facilitate peer discussion of LDSS/State issues.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Waiver case files:
Ten percent of waiver cases are randomly selected for review. The materials reviewed include the child's assessments, physician orders, case management plans, budgets and claim detail reports. Documents are reviewed for proper signatures and dates, timely completion, follow-through on the medical plan and overall plan of care, and utilization of services. Case management notes are also reviewed in order to substantiate billings and subsequent Medicaid reimbursement.

Tracking reports:
Quarterly reports from LDSS are used as a tracking tool to monitor program activity within each district, recipient movement across district lines, and home and vehicle modifications.

Conference calls:
These calls enable the sharing and peer discussion of LDSS issues. State DOH staff may also present new directives or waiver topics.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The remediation process is initiated when the LDSS CAH I/II coordinator or NYSDOH waiver management staff identify a lack in the quality of provided services, or any other issue related to administration of CAH I/II.

In such situations, the standard procedure is for NYSDOH waiver management staff and the LDSS CAH I/II coordinator to discuss the situation and collaboratively develop a plan of correction. Implementation and compliance with the plan of correction is monitored by NYSDOH and LDSS staff.

Should the plan of correction require a change in the participant's service, the NYSDOH waiver management staff and the LDSS CAH I/II coordinator will work cooperatively to address the service deficiency and when necessary, transition the child to another CAH I/II provider. To ensure continuity of service during the transition period, the original provider will be required to transfer the CAH I/II participant case records and other pertinent documents to the new provider.

Remediation of financial issues begins immediately upon the discovery of any impropriety. The NYSDOH waiver management staff, and other NYSDOH staff as appropriate, will immediately initiate remediation of any inappropriate claims processed through eMedNY. Remediation may include voiding payments, assigning penalties and sanctioning providers. In the case of home and vehicle modifications, LDSS staff will initiate remediation by cancelling payments to home and vehicle contractors. The LDSS staff will initiate remediation of any inappropriate claims processed on Schedule E.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide CAH I/II services. Accordingly, NYSDOH waiver management staff will issue a letter to the provider terminating their CAH I/II waiver provider status.

Unsatisfactory home and vehicle modification contractors will be notified of their disqualification from further service by the administering LDSS. The LDSS CAH I/II coordinator will help the family find alternate contractors and craftsmen.

Documentation of remediation activities is accomplished by the following measures: correspondence between NYSDOH waiver management staff, the LDSS CAH I/II coordinator, participants and their parents/legal guardians, and/or service providers; amended plans of care; LDSS case reviews and reports of follow-up meetings with participants and their families; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file and, as appropriate, by NYSDOH/OLTC.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

■ **No**

■ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
	☐	**Aged**			☐
	☑	**Disabled (Physical)**	0	17	
	☐	**Disabled (Other)**			
Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
Mental Retardation or Developmental Disability, or Both					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Mental Retardation**			☐
Mental Illness					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The State further specifies its target group(s) as follows:

The State further specifies its target group as those individuals under the age of eighteen who are not married.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

■ **Not applicable. There is no maximum age limit**

■ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - **A level higher than 100% of the institutional average.**

    Specify the percentage: _____

  - **Other**

    Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the State is *(select one)*:

  - **The following dollar amount:**

    Specify dollar amount: _____

    The dollar amount *(select one)*

    - **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

■ **The following percentage that is less than 100% of the institutional average:**

Specify percent: _____

■ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2292
Year 2	3698
Year 3	3698
Year 4 (renewal only)	3698
Year 5 (renewal only)	3698

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- **The waiver is not subject to a phase-in or a phase-out schedule.**
- **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

■ **Waiver capacity is allocated/managed on a statewide basis.**

■ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The CAH I/II waiver provides enrollment for eligible children. Individuals applying must be: under 18 years of age, physically disabled based on SSI criteria, require the level of care provided in a nursing facility or hospital, be capable of being cared for in the community if provided with case management services, respite, home adaptation, and palliative care services.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ■ **§1634 State**
   - ■ **SSI Criteria State**
   - ■ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ■ **No**
   - ■ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☑ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☑ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- **100% of the Federal poverty level (FPL)**
- **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- **Medically needy in 209(b) States (42 CFR §435.330)**
- **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Children who qualify under 1902(a)(10)(A)(i)(IV) for infants under one year of age , 1902(a)(10)(A)(i)(VI) children who have attained one year of age but have not attained six years of age, 1902(a)(10)(A)(i)(VII) children who have attained six years of age but have not yet attained nineteen years of age, 1902(a)(10)(A)(ii)(VIII) children who qualify under State adoption assistance, 1902(e)(12) children who are eligible for continuous coverage, and 1902(a)(10)(A)(i)(I) children for whom an adoption agreement is in effect or foster care maintainence payments are being made under title IV-E of the Act, and children covered under 1902(a)(10)(A)(i)(II)(aa).

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- **A special income level equal to:**

Select one:

- **300% of the SSI Federal Benefit Rate (FBR)**
- **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

■ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

■ **100% of FPL**

■ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- ■ **The provision of waiver services at least monthly**
- ■ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ■ **Directly by the Medicaid agency**

- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

  Specify the entity:

- **Other**
  Specify:

  RN from the Local Department of Social Services(LDSS)or Health, Certified Home Health Agency (CHHA), Developmental Disability Services Organization (DDSO), or Community Alternative Systems Agency (CASA) designated by the LDSS.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The initial evaluation of level of care for CAH I/II waiver applicants is performed by a Registered Nurse (RN) currently registered and licensed in the State of New York and employed by a Local Department of Social Services (LDSS) or Health, Certified Home Health Agency (CHHA), Developmental Disability Services Organization (DDSO), or Community Alternative Systems Agency (CASA).

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Certain Level of Care (LOC) criteria are used to evaluate whether an applicant/participant requires and/or continues to require CAH I/II waiver services. The applicant/participant must be under the age of 18; have been determined disabled according to SSI criteria; and require either a skilled nursing facility or hospital level of care. The CAH I/II Pediatric Patient Review Instrument (PPRI) is used to determine the initial LOC (hospital or nursing facility) and is updated every six months or as the participant's medical or other condition affecting the level of care changes.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

  Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

  The CAH I/II PPRI is used only to evaluate LOC for the CAH I/II waiver applicant/participant. There is no institutional LOC measurement used for children, nor is there a tool under the State Plan to evaluate either an adult's or a child's need for hospital LOC.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Pediatric Patient Review Instrument (PPRI) assessment tool is designed to evaluate the level of care (skilled facility or hospital level of care) for CAH I/II. The Local Department of Social Services (LDSS) CAH Coordinator is responsible for arranging the assessment. The PPRI assessment must be completed by a Registered Nurse (RN) designated by the LDSS prior to a child's enrollment in CAH I/II, and at a minimum, annually thereafter for those enrolled in the waiver. The information collected, at a minimum, includes: family background, diagnosis, a complete description of the child's medical condition, type and frequency of needed medical interventions, developmental level of the child, and any other medical or social information pertinent to the child in order to determine and document the level of care (LOC) (skilled facility or hospital) at which the child is assessed.

If the assessing RN needs additional information to accurately complete the PPRI and make a LOC determination, he/she may directly request the information from the parent, child if appropriate, or the child's physician. In some instances, the RN will ask the LDSS CAH Coordinator to assist in obtaining the necessary information from the appropriate source.

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g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- **Every three months**
- **Every six months**
- **Every twelve months**
- **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

A RN, designated by the LDSS CAH coordinator, completes the Pediatric Patient Review Instrument (PPRI) on an annual basis or whenever there is a change in the enrollee's medical status. In accordance with program guidelines, the CAH case managers are required to assist the participant/family in understanding, meeting and completing necessary program requirements such as the annual level of care re-evaluation.

Each LDSS CAH coordinator maintains a file or log which indicates when each participant's level of care re-evaluation is due. This is usually part of a larger re-assessment package which may include Medicaid eligibility and disability re-certification, physician orders and case management plan of service. As part of his or her role for oversight of children in their district enrolled in the CAH I/II waiver, the LDSS CAH coordinator maintains regular contact with the CAH case managers to discuss the progress of the case,identify needs, and solve problems.

During the annual review, the DOH waiver management staff review the participant's case record to ensure that the annual level of care documentation (PPRI) as well as other documentation that comprises the re-assessment package was completed in a timely manner, and supports the annual level of care determination.

If there is a change in the particpant's medical condition or home situation which necessitates a re-evaluation, the LDSS CAH coordinator requests a re-assessment by an RN from a designated agency. The re-assessment documentaion, including the PPRI, indicates the findings of the assessing RN. In addition, all documentation for re-evaluations are submitted to the LDSS CAH coordinator.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Local districts must retain the letter of notification, level of care determinations, home assessments, plans of care, expenditure estimates and all other information pertaining to the child's enrollment and continued eligibility for the waiver in the waiver applicant's file. This information must be retained for the duration of the child's enrollment in the waiver and for at least six years after the child's eighteenth birthday for possible post-audit and evaluation by either state or federal agents.

A copy of the initial evaluation of the waiver applicant is kept on file by the NYSDOH/OLTC.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of all waiver applicants who have a completed PPRI and Plan of Services Form that identifies and addresses the child's assessed need(s), including available providers, and if appropriate, and a resolution date for the plan of care goal being addressed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: LDSS	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: LDSS	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of all Plan of Services Forms, which include reference to the PPRI, signed and dated by the parent of the waiver participant as well as the CAH I/II case manager that have the date of the next scheduled review date of the plan indicated on the form.

Data Source (Select one):

Other
If 'Other' is selected, specify:
On-site and central record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of all CAH I/II waiver participants who have their PPRI and Plan of Services regularly re-evaluated and updated in conjunction with the 6 month assessment or more often as indicated by a change in the child's medical condition or other situation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The remediation process is initiated when the LDSS CAH I/II coordinator or NYSDOH waiver management staff identify a lack in the quality of provided services, or any other issue related to administration of CAH I/II.

In such situations, the standard procedure is for NYSDOH waiver management staff and the LDSS CAH I/II coordinator to discuss the situation and collaboratively develop a plan of correction. Implementation and compliance with the plan of correction is monitored by NYSDOH and LDSS staff.

Should the plan of correction require a change in the participant's service, the NYSDOH waiver management staff and the LDSS CAH I/II coordinator will work cooperatively to address the service deficiency and when necessary, transition the child to another CAH I/II provider. To ensure continuity of service during the transition period, the original provider will be required to transfer the CAH I/II participant case records and other pertinent documents to the new provider.

Remediation of financial issues begins immediately upon the discovery of any impropriety. The NYSDOH waiver management staff, and other Department staff as appropriate, will immediately initiate remediation of any inappropriate claims processed through eMedNY. Remediation may include voiding payments, assigning penalties and sanctioning providers. In the case of home and vehicle modifications, LDSS staff will initiate remediation by cancelling payments to home and vehicle contractors. The LDSS staff will initiate remediation of any inappropriate claims processed on Schedule E.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide CAH I/II services. Accordingly, NYSDOH waiver management staff will issue a letter to the provider terminating their CAH I/II waiver provider status.

Unsatisfactory home and vehicle modification contractors will be notified of their disqualification from further service by the administering LDSS. The LDSS CAH I/II coordinator will help the family find alternate contractors and craftsmen.

Documentation of remediation activities is accomplished by the following measures: correspondence between NYSDOH waiver management staff, the LDSS CAH I/II coordinator, participants' and their parents/legal guardians, and/or service providers; amended plans of care; LDSS case reviews and reports of follow-up meetings with participants and their families; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file and, as appropriate, by NYSDOH/OLTC.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

■ **No**

■ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

At the time of application for enrollment in the waiver, the LDSS ensures that eligible individuals have been informed

of feasible alternatives for care. The applicant's parents/legal guardians are required to sign the Choice of Care form indicating their decision whether or not to have their child receive services under the Medicaid waiver. This form must be witnessed and dated; it is kept as part of the applicant's permanent case file at the LDSS and a copy is forwarded to NYSDOH.

The LDSS also informs parents/legal guardians of the case management agencies available in the LDSS catchment area. The parents/legal guardians must sign the Choice of Case Management Selection form indicating their choice of case manager for their child. This form is is kept as part of the applicant's permanent case file at the LDSS and a copy is forwarded to NYSDOH.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Freedom of Choice forms are kept on file at the LDSS in the applicant's case file and copies are kept at the NYSDOH/OLTC.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Persons with limited fluency in the English language must be able to apply for benefits without undue hardship. LDSS offices must have arrangements to provide interpretation or translation services for a person who will need them. Non-English speaking applicants may bring a translator of their choice with them to the local social services district. However, applicants may not be required to bring their own translator, and no person can be denied access on the basis of a District's inability to provide adequate translations. [NYS DOH GIS 99 MA/021 and 95 INF-15]

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	**Case Management**
Other Service	**Bereavement Services**
Other Service	**Expressive Therapies**
Other Service	**Family Palliative Care Education (Training)**
Other Service	**Home and Vehicle Modification**
Other Service	**Massage Therapy**
Other Service	**Pain and Symptom Management**
Other Service	**Respite**

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Service Definition *(Scope):*

Case management encompasses a wide range of activities the objectives and functions of which include: assisting children and families gain access to MA State Plan and other specified community based services; developing and implementing a plan of care that meets the needs of the participant; assuring that services are provided in a cost effective manner in accordance with the plan of care; and maximizing private health insurance for covered services.

The CAH I/II case manager will assume the case management role for CAH I/II children who concurrently receive services in the State's Early Intervention Program. The participant's parent/legal guardian must select a case manager before the waiver application is submitted to NYSDOH waiver management staff.

In accordance with federal and state regulations, the participant must be offered freedom of choice when choosing a MA provider at the time of application. The selected case management agency must meet the qualifications as outlined in NYS Regulations 18 NYCRR 505.16 and be enrolled as a CAH I/II case management provider. The availability of case management agencies varies throughout the State. In the absence of an available case management agency or when one is not chosen by the participant or their parent/legal guardian, the LDSS will be directly responsible for the provision of CAH I/II case management services. Additional information specifically concerning case management in the CAH I/II program is found in administrative directive 90 ADM-20.

Agencies authorized to provide case management to a child are:
• Community Alternative Systems Agencies (CASA),
• Local Government Agencies (LDSS and Local Department of Health),
• Professional Case Management Agencies enrolled as a CAH I/II provider.

The LDSS is responsible for monitoring the case manager's performance (unless it assumes the case management functions): maintenance of a current case management plan that meets the child's evolving medical needs based upon the physician's approved plan of care, the timely provision of physician's orders, and completion of assessments/reassessments at the required six month intervals.

CAH I/II case managers must adhere to all Medicaid rules and regulations, and follow established program policy. Specifically, the case manager will:
• Assist children and their families gain access to the full range of available community based services.
• Assure provided services match the particular needs of the participant and their family.
• Encourage active participation of the participant's family in the plan of care.
• Assure family and home health care providers have taken reasonable steps to maintain the child's health and safety in the community.
• Assure MA services are delivered in a cost effective manner and that alternate sources of reimbursement, such as private health insurance, are maximized.
• Request and review MA paid claim reports on a regular basis to compare services listed in the Plan of Care to services reimbursed by Medicaid. Discrepancies should be reported to the LDSS CAH I/II coordinator and the NYSDOH.
• Assist with the development of the Plan of Care and its update, at a minimum every 180 days corresponding to the child's reassessment, and assure Plan of Care implementation.
• Maintain regular contact with the LDSS, CAH I/II coordinator the child and his/her parent/legal guardian. At a minimum, the case manager will maintain monthly contact with the participant. It is recommended that the case manger accompany the assessing nurse on visits to the child's home.

Note: This service does not duplicate other services available through the New York Medicaid State Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Case Management Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Case Management Agencies/Case Managers: 18 NYCRR 505.16; Application to NYSDOH; as outlined in
90 ADM-20:18
Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH will verify the case management agency's qualifications.
Frequency of Verification:
Verification of the Case Management Agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:

Bereavement Services
Service Definition *(Scope):*
Bereavement Services will be made available to waiver participants and their families to help them cope with grief related to the challenges of the end of life experience. This service will include, but not be limited to, opportunities for individual, family, or group counseling.

Approved service providers will be social workers, hospice bereavement staff, and/or other appropriate licensed professionals employed by a Certified Home health Agency (CHHA) or Hospice and who have specialized training and experience working with children and their families who are in need of counseling to address end-of-life issues related to their illness.

Bereavement services may be provided to informal caregivers and family supports as requested by the family. The counseling must be initiated and billed while the child is participating in the CAH I/II waiver but may continue, if requested, at no additional charge by the provider for up to one year after the death of the child. Services may be provided in the home of the participant/family or other appropriate setting.

Note: This service is available only to the child and other persons who provide uncompensated care and support to the participant in areas specified in the service plan. Individuals who are employed to support the participant may not receive this service. This service does not duplicate other services available through the New York Medicaid State Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
120 Hours annually; must be initiated prior to the death of the participant and discontinued within one year thereafter.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospice Agency
Agency	Certified Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Bereavement Services

Provider Category:
Agency
Provider Type:
Hospice Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
PHL Section 4008; 10 NYCRR Section 791.2
Other Standard *(specify):*

The Provider must employ a Bereavement Counselor who meets the following qualifications:

Clinical Social Worker currently licensed in New York State pursuant to NYS Education Law, Article 154, Social Work, preferably having three years clinical pediatric and one year clinical end of life care experience; or

Psychologist currently licensed in New York State pursuant to NYS Education Law, Article 153, Psychology, preferably having three years clinical pediatric and one year clinical end of life care experience; or

Mental Health Counselor currently licensed in New York State, pursuant to NYS Education Law, Article 163, Mental Health Practitioners, Section 8402, Mental Health Counseling, preferably having three years clinical pediatric and one year clinical end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:
NYSDOH will verify Medicaid enrollment for each provider type. The Hospice is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:
Verification of the Hospice agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The Hospice Agency must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Bereavement Services

Provider Category:
Agency

Provider Type:
Certified Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
PHL Sections 3602, 3606

Other Standard *(specify):*
The Provider must employ a Bereavement Counselor who meets the following qualifications:

Clinical Social Worker currently licensed in New York State pursuant to NYS Education Law, Article 154, Social Work, preferably having three years clinical pediatric and one year clinical end of life care experience; or

Psychologist currently licensed in New York State pursuant to NYS Education Law, Article 153, Psychology, preferably having three years clinical pediatric and one year clinical end of life care experience; or

Mental Health Counselor currently licensed in New York State, pursuant to NYS Education Law, Article 163, Mental Health Practitioners, Section 8402, Mental Health Counseling, preferably having three years clinical pediatric and one year clinical end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify Medicaid enrollment for each provider type. The CHHA is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:

Verification of the CHHA is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The CHHA must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Expressive Therapies

Service Definition *(Scope):*

Expressive Therapies are aimed at assisting children meet the challenges of their end of life experience. Included specialty services are intended to help children better understand and express their reactions through professionally led creative and kinesthetic treatment modalities designed specifically for the CAH I/II participant and their sibling, if any. Certified art, music, and play therapists and child life specialists will treat emotional distress associated with the participant's diagnosis by providing age-appropriate information about the plan of care, course of treatment, end of life experience, and useful coping strategies to ease anticipatory anxiety regarding upcoming treatments and procedures.

Expressive therapies, including Music, Art, and Play therapy, must be provided in accordance with the participant's plan of care and as appropriate to the child's end of life condition and challenges.

Note: This service does not duplicate other services available through the New York Medicaid State Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

One hour per week; not to exceed 5 hours per month.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospice Agency

Agency	Certified Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Expressive Therapies

Provider Category:
Agency
Provider Type:
Hospice Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
PHL Section 4008; 10 NYCRR Section 791.2
Other Standard *(specify):*
The Provider must employ, or ensure access to, Expressive Therapists who meet the following qualifications:

Child Life Specialist, currently certified through the Child Life Council, a national professional organization that administers a standard credentialing process, and have preferably three years clinical pediatric and one year clinical end of life care experience; or

Creative Arts Therapist, currently licensed in New York State pursuant to NYS Education Law, Article 163, Mental Health Practitioners, and have preferably three years clinical pediatric and one year clinical end of life care experience; or

Music Therapist with a Bachelor's degree in Music Therapy from a program recognized by the New York State Education Department, registered with a nationally recognized organization for Music Therapy professionals, and preferably have one year clinical end of life care experience; or

Play Therapist with a Master's degree from a program recognized by the NYS Education Department, and with the credential of Registered Play Therapist conferred by the Association for Play Therapy, and preferably have three years clinical pediatric experience, and one year clinical end of life care experience; and

All expressive therapists must demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH will verify Medicaid enrollment for each provider type. The Hospice is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.
Frequency of Verification:
Verification of the Hospice agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The Hospice Agency must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Expressive Therapies

Provider Category:

Agency

Provider Type:

Certified Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

PHL Sections 3602, 3606

Other Standard *(specify):*

The Provider must employ, or ensure access to, Expressive Therapists who meet the following qualifications:

Child Life Specialist, currently certified through the Child Life Council, a national professional organization that administers a standard credentialing process, and have preferably three years clinical pediatric and one year clinical end of life care experience; or

Creative Arts Therapist, currently licensed in New York State pursuant to NYS Education Law, Article 163, Mental Health Practitioners, and have preferably three years clinical pediatric and one year clinical end of life care experience; or

Music Therapist with a Bachelor's degree in Music Therapy from a program recognized by the New York State Education Department, registered with a nationally recognized organization for Music Therapy professionals, and preferably have one year clinical end of life care experience; or

Play Therapist with a Master's degree from a program recognized by the NYS Education Department, and with the credential of Registered Play Therapist conferred by the Association for Play Therapy, and preferably have three years clinical pediatric experience, and one year clinical end of life care experience; and

All expressive therapists must demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify Medicaid enrollment for each provider type. The CHHA is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:

Verification of the CHHA is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The CHHA must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Family Palliative Care Education (Training)
Service Definition *(Scope):*
Family Palliative Care Education (Family Training) provides, as appropriate, direct instruction and guidance aimed at the principles of end of life care for CAH I/II waiver participants, their families and extended network of support, and other potential informal caregivers. The service may be provided by a registered nurse or social worker who has special training in pediatric palliative care.

Family Training providers use specialized assessment and intervention skills to address the physical, psychological and spiritual issues associated with the waiver participant's complex end of life conditions for which curative treatment may fail, is not possible, or because of which an early death is likely. This service is designed to meet the needs of each individual participant and their family. The service is aimed at but not limited to instruction in palliative principles and end of life care, and familiarization with the expected trajectory of a child's illness/medical treatment regimens, related services included in the participant's plan of care, and the process for making funeral arrangements.

The Family Trainer will share observations and concerns regarding the child's life threatening condition and identified changing service needs related to the end-of-life experience with the participant's interdisciplinary team.

Note: This service is available only to the participant and other persons who provide uncompensated care and support to the participant in areas specified in the service plan. Individuals who are employed to support the participant may not receive this service. This service does not duplicate other services available through the New York Medicaid State Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
100 Hours annually.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Home Health Agency
Agency	Hospice Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Palliative Care Education (Training)

Provider Category:
Agency
Provider Type:
Certified Home Health Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
PHL Sections 3602, 3606
Other Standard *(specify):*
The Provider must employ a Family Palliative Care Trainer who meets the following qualifications:

Registered Nurse currently licensed and registered pursuant to the provisions of the New York State Education Law, Article 139, Nursing, preferably having at least three years clinical pediatric care and one year clinical end of life care experience; or

Medical Social Worker having a Master's degree in Social Work, and preferably have at least three years clinical pediatric care experience and one year clinical end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:
NYSDOH will verify Medicaid enrollment for each provider type. The CHHA is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:
Verification of the CHHA is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The Hospice Agency must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Palliative Care Education (Training)

Provider Category:
Agency
Provider Type:
Hospice Agency
Provider Qualifications

License *(specify):*

Certificate *(specify):*
PHL Section 4008; 10 NYCRR Section 791.2
Other Standard *(specify):*
The Provider must employ a Family Palliative Care Trainer who meets the following qualifications:

Registered Nurse currently licensed and registered pursuant to the provisions of the New York State Education Law, Article 139, Nursing, preferably having at least three years clinical pediatric care and one year clinical end of life care experience; or

Medical Social Worker having a Master's degree in Social Work and preferably have at least three years clinical pediatric care experience and one year clinical end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:
NYSDOH will verify Medicaid enrollment for each provider type. The Hospice agency is responsible for verifying that individual employees maintain necessary licensure, certification, and

meet all training requirements.
Frequency of Verification:
Verification of the Hospice agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The Hospice Agency must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home and Vehicle Modification
Service Definition *(Scope):*
Modifications to the private residence of a waiver participant are provided, in accordance with the participant's plan of care, to ensure the health, welfare and safety of the child and to enable him/her greater functionality and independence in the home. Such modification may include: the installation of ramps, grab bars, and wheelchair or ceiling lifts; the widening of doorways; and bathrooms accessibility, electrical and plumbing system retro-fits. The service also includes modification of the family vehicle when required by the child's service plan to provide safe access to the community.

Excluded from this benefit are modifications or improvements that are not of direct medical or remedial benefit to the child, and those that add to the total square footage of the home.

LDSS contracts with local evaluators and independent licensed crafts persons, or in the case of vehicle modifications with evaluators and modifiers approved by the NYS Education Department's Office of Vocational and Educational Services, to determine the need for the service, the safety of the proposed modification, its expected benefit to the child, and the most cost effective approach in fulfilling the child's need. Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that contractors are qualified and that State required bidding procedures have been followed.
Note: This service does not duplicate other services available through the New York Medicaid State Plan. The limit on amount represents a change from the current waiver lifetime cap for home and vehicle modifications of $14,000 and $20,000 respectively.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is a five year $20,000 spending threshold for home and vehicle modifications. DOH may increase the threshold amount if there is significant change in the child's needs or capabilities.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Agency	Home and Vehicle Modification Contractor/Craftsman

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home and Vehicle Modification

Provider Category:
Agency
Provider Type:
Home and Vehicle Modification Contractor/Craftsman
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
LDSS staff verify the qualifications of home modification providers. The NYS Education Department's Office of Vocational and Educational Services (VESID) verifies the credential of vehicle modification providers. NYF Fire Prevention and Billing Codes, 00 OMM/ADM 4
Verification of Provider Qualifications
Entity Responsible for Verification:
LDSS
Frequency of Verification:
Provider qualifications are verified at the beginning of the home modification contract by the LDSS and/or at the beginning of the vehicle modification contract by VESID. NYF Fire Prevention and Billing Codes, 00 OMM/ADM 4

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Massage Therapy
Service Definition *(Scope):*
Massage Therapists apply a scientific system of activity to the muscular structure of the human body for the purpose of improving muscle tone and circulation. The aim of the therapy is to promote relaxation, manage musculoskeletal pain, and relieve fear and stress associated with the participant's end of life experience. Massage therapy services may be complementary to physical therapy or rendered as a less intrusive alternative.

The service will be provided in accordance with the participants' plan of care by NYS licensed massage therapists. Assessment to determine the specific therapeutic massage activities to be used and the need for continued therapy is also an included service.

Note: This service does not duplicate other services available through the New York Medicaid State Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Maximum one hour per week; not to exceed 5 hours per month.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospice Agency
Agency	Certified Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:
Agency

Provider Type:
Hospice Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
PHL Section 4008; 10 NYCRR Section 791.2

Other Standard *(specify):*
The Provider must employ, or ensure access to, a Massage Therapist who meets the following qualifications:

Massage Therapist currently licensed and registered in New York State pursuant to NYS Education Law, Article 155, Massage Therapy, preferably having end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications

Entity Responsible for Verification:
NYSDOH will verify Medicaid enrollment for each provider type. The Hospice is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.

Frequency of Verification:
Verification of the Hospice is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The Hospice must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:
Agency
Provider Type:
Certified Home Health Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
PHL Sections 3602, 3606
Other Standard *(specify):*
The Provider must employ, or ensure access to, a Massage Therapist who meets the following qualifications:

Massage Therapist currently licensed and registered in New York State pursuant to NYS Education Law, Article 155, Massage Therapy, preferably having end of life care experience; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH will verify Medicaid enrollment for each provider type. The CHHA is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.
Frequency of Verification:
Verification of the CHHA is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The CHHA must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Pain and Symptom Management
Service Definition *(Scope):*
Pain and symptom management consultation services are aimed at the relief and/or control of participants' suffering related to their end of life experience. The service will be provided in accordance with the participant's plan of care by specially trained clinical consultants limited to licensed Pediatric or Family Medicine physicians or Nurse Practitioners who have documented expertise in pediatric pain management.

Note: This service does not duplicate or replace other services available through the New York Medicaid State Plan. This service does not include pharmaceuticals.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
No limit; as required by participant's physician or nurse practitioner.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospice Agency
Agency	Certified Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Pain and Symptom Management

Provider Category:
Agency
Provider Type:
Hospice Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
PHL Section 4008; 10 NYCRR Section 791.2
Other Standard *(specify):*
The Provider must ensure access to a specially trained consultant who meets the following qualifications:

Pediatrician or Family Medicine physician currently licensed in New York State pursuant to NYS Education Law, Article 131, Medicine, preferably certified by the American Board of Medical Specialties, Royal College of Physicians and Surgeons of Canada, or La Corporation Professelle des Medicins du Quebec in Hospice And Palliative Medicine, and having at least three years clinical pediatric and one year clinical end of life care experience; or

Nurse Practitioner currently licensed and certified in New York State, pursuant to NYS Education Law, Article 139, Nursing, Section 6910, preferably having three years clinical pediatric experience, one year clinical end of life care experience, and have served as a member of a pain and symptom management clinical team for the evaluation and treatment of infant, child and adolescent pain; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH will verify Medicaid enrollment for each provider type. The Hospice agency is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.
Frequency of Verification:
Verification of the Hospice agency is conducted prior to signing the NYSDOH provider agreement,

and thereafter, according to the applicable policy of NYSDOH. The Hospice agency must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Pain and Symptom Management

Provider Category:
Agency
Provider Type:
Certified Home Health Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
PHL Sections 3602, 3606
Other Standard *(specify):*
The Provider must ensure access to a specially trained consultant who meets the following qualifications:

Pediatrician or Family Medicine physician currently licensed in New York State pursuant to NYS Education Law, Article 131, Medicine, preferably certified by the American Board of Medical Specialties, Royal College of Physicians and Surgeons of Canada, or La Corporation Professelle des Medicins du Quebec in Hospice And Palliative Medicine, and having at least three years clinical pediatric and one year clinical end of life care experience; or

Nurse Practitioner currently licensed and certified in New York State, pursuant to NYS Education Law, Article 139, Nursing, Section 6910, preferably having three years clinical pediatric experience, one year clinical end of life care experience, and have served as a member of a pain and symptom management clinical team for the evaluation and treatment of infant, child and adolescent pain; and must

Demonstrate ongoing proficiency in the principles of end of life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end of life care.

Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH will verify Medicaid enrollment for each provider type. The CHHA is responsible for verifying that individual employees maintain necessary licensure, certification, and meet all training requirements.
Frequency of Verification:
Verification of the CHHA is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH. The CHHA must verify licensure and/or certification of employees upon hire and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Respite

Service Definition *(Scope):*

CAH I/II provides respite services to the participant's informal caregiver(s) as temporary relief from their special child care duties. Respite care is provided in accordance with the participant's plan of care, as approved by the physician, case manager, LDSS CAH I/II coordinator and in conference with the child and his/her family, so that essential medical tasks are continued to maintain the participant's health and safety.

Respite service is contingent upon the availability of providers. Respite is not provided when the participant is an inpatient of a hospital for a medical procedure.

Note: This service does not duplicate other services available through the New York Medicaid State Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Intermediate Care Facility
Agency	Skilled Nursing Facility (SNF)
Agency	Hospital

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Intermediate Care Facility

Provider Qualifications

License *(specify):*

42 CFR 440.150, 14 NYCRR Part 681

Certificate *(specify):*

Issued by OMRDD

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

OMRDD
Frequency of Verification:
8 - 15 months

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Skilled Nursing Facility (SNF)
Provider Qualifications
License *(specify):*

Certificate *(specify):*
PHL Article 28-A
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH
Frequency of Verification:
Every 15 months or when necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Hospital
Provider Qualifications
License *(specify):*

Certificate *(specify):*
New York State Public Health Law, Article 28, Section 2801-f
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
NYSDOH
Frequency of Verification:
Every 15 months or when necessary.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ■ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ■ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:
  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☑ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Agencies authorized to provide case management to a child are:

Community Alternative Systems Agencies (CASA)

Local Government Agencies

Professional Case Management Agencies enrolled as a CAH I/II provider

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ■ **No. Criminal history and/or background investigations are not required.**
- ■ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

In accordance with Public Health Law section 2899-a and Executive Law section 845-b, any certified home health agency, hospice, licensed home care services agency or long term home health care program certified, licensed or authorized under Articles 36 and 40 of the Public Health Law to provide services to patients, residents or clients shall request a criminal history record check by the New York State Department of Health (NYSDOH) and the NYS Division of Criminal Justice Services for each prospective employee that will provide direct care or supervision to patients, residents or clients.

The term employee does not include persons licensed pursuant to Title 8 of the Education Law or Article 28-D of the Public Health Law. Title 10 of the Official Compilation of Codes, Rules and Regulations for the State of New York (NYCRR) Part 402 establishes the process for conducting the investigation and the standards for

review by the Department of Health. Each provider must develop and implement written policies and procedures that include protecting the safety of persons receiving services from temporary employees consistent with the NYS regulations (e.g., appropriate direct observation and evaluation).

A provider requesting a criminal history record check obtains the fingerprints accompanied by two forms of identification from the prospective employee to be submitted to NYSDOH. Providers must maintain and retain current records, including a roster of current employees who were so reviewed, to which NYSDOH shall have immediate and unrestricted access for the purpose of monitoring compliance with these provisions.

Verification of compliance with the criminal history record check regulations is an element of the NYSDOH surveillance process. At the time of surveillance, NYSDOH surveyors utilize a standardized tool to evaluate compliance with the criminal history background checks regulations. If a provider is found not to be in compliance with the regulations, a statement of deficiency (ies) is issued for which the provider has to provide a plan of correction.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

■ **No. The State does not conduct abuse registry screening.**

■ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

■ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**

■ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

■ **No. The State does not make payment to legally responsible individuals for furnishing personal care or**

similar services.

■ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

■ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**

■ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

■ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

■ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of approved waiver provider applications that demonstrate compliance with required qualifications and competencies for CAH I/II service provision.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of providers that demonstrate continuous compliance with required qualifications and competencies for CAH I/II service provision.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% annual review and as deemed necessary
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of non-licensed/non-certified provider applicants that meet provider qualifications in accordance with State Law and/or waiver requirements.

Data Source (Select one):

Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: LDSS CAH I/II Coordinator for Home and Vehicle Modifications	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: LDSS CAH I/II Coordinator for Home and Vehicle Modifications	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of non-licensed/non-certified providers that continue to meet waiver provider qualifications where applicable in accordance with State Law and waiver provider requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: LDSS CAH I/II Coordinator for Home and Vehicle Modifications	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 10% annual review and as deemed necessary
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: LDSS CAH I/II Coordinator for Home and Vehicle Modifications	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of CAH I/II waiver providers, where applicable, meeting provider training requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☑ **Other** Specify: 10% annual review and as deemed necessary
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The remediation process is initiated when the LDSS CAH I/II coordinator or NYSDOH waiver management staff identify a lack in the quality of provided services, or any other issue related to administration of CAH I/II.

In such situations, the standard procedure is for NYSDOH waiver management staff and the LDSS CAH I/II coordinator to discuss the situation and collaboratively develop a plan of correction. Implementation and compliance with the plan of correction is monitored by NYSDOH and LDSS staff.

Should the plan of correction require a change in the participant's service, the NYSDOH waiver management staff and the LDSS CAH I/II coordinator will work cooperatively to address the service deficiency and when necessary, transition the child to another CAH I/II provider. To ensure continuity of service during the

transition period, the original provider will be required to transfer the CAH I/II participant case records and other pertinent documents to the new provider.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide CAH I/II services. Accordingly, NYSDOH waiver management staff will issue a letter to the provider terminating their CAH I/II waiver provider status.

Unsatisfactory home and vehicle modification contractors will be notified of their disqualification from further service by the administering LDSS. The LDSS CAH I/II coordinator will help the family find alternate contractors and craftsmen.

Documentation of remediation activities is accomplished by the following measures: correspondence between NYSDOH waiver management staff, the LDSS CAH I/II coordinator, participants' and their parents/legal guardians, and/or service providers; amended plans of care; LDSS case reviews and reports of follow-up meetings with participants and their families; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file and, as appropriate, by NYSDOH/OLTC.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: LDSS CAH I/II Coordinator for Home and Vehicle Modifications	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

■ **No**

■ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ■ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ■ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.

- ☐ **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
CAH I/II Plan of Care

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☑ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☑ **Licensed physician (M.D. or D.O)**

☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

☐ **Social Worker.**

Specify qualifications:

☑ **Other**

Specify the individuals and their qualifications:

LDSS CAH I/II Coordinator

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

■ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

■ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The NYSDOH maintains safeguards to ensure the appropriateness of participant plans of care that are primarily reflected in the team approach to service plan development. The LDSS CAH I/II coordinator along with the CAH I/II case manager, the assessing agency's Registered Nurse (RN), and primary care physician all assist in the development of the waiver applicant's plan of care.

The LDSS CAH I/II coordinator provides waiver oversight, authorizes the child's program participation and approves all proposed plans of care. A RN from the designated agency assesses the needs of the waiver applicant and then consults with the applicant's physician and CAH case manager to develop the overall plan of care.

The plan of care consists of five documents: the Pediatric Patient Review Instrument (PPRI) and completion of an approved home care assessment form signed and dated by the designated RN and the LDSS; signed and dated physician orders authorizing services; the Plan of Services Form signed and dated by the CAH case manager and the applicant's parent(s)/legal guardians; and a budget indicating authorized services and various payment sources.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The parents/legal guardians, along with the waiver applicant/participant as appropriate, actively participate in the

development of the plan of care and selection of service providers.

Upon application, the LDSS is responsible for providing the applicant's parents(s)/legal guardians with information about waiver eligibility and enrollment criteria, and the various options for service. The applicant's parents/legal guardians are informed of their choice of system of care—institutionalization or community based waiver program, as well as the choice of available waiver services and MA state plan and waiver service providers. The parents/legal guardians of waiver participants must sign a Freedom of Choice form, witnessed and dated, indicating their decision to enroll the child in the CAH I/II waiver program. The parents/legal guardians also sign the Case Management Agency Selection form, indicating their choice for their child. A copy of each of these forms are given to the parent, and maintained in LDSS and case management agency files; copies are also forwarded and maintained in NYSDOH CAH I/II records.

A copy of the "Care At Home Parent Handbook", explaining the waiver program, is given to new waiver participants and is available on the NYSDOH website for all consumers. Applicants have a choice of programs as well as service providers. Each LDSS CAH I/II coordinator has a list of available waiver and State Plan MA providers that is shared with the participants and their parent(s)/legal guardians.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Introduction

Each Local Department of Social Services (LDSS) Commissioner designates a CAH I/II coordinator. The LDSS CAH I/II coordinator is the primary contact with NYSDOH waiver management staff, CAH I/II case managers and family of the applicant/participant. The LDSS CAH I/II coordinator has responsibility to ensure that the plan for waiver services—referred to in CAH I/II as the Plan of Care—is developed in accordance with waiver policy and protocols.

The service planning process begins with an assessment of the applicant's medical needs and available community supports, and determination that the applicant needs skilled nursing facility or hospital level of care as required for participation in CAH I/II. The CAH I/II case manager uses the assessment to develop a Plan of Care that must be authorized by order of the applicant's physician, and projects the cost of service (budget) for each waiver applicant.

Assessment

The LDSS CAH I/II coordinator arranges for a Registered Nurse (RN) employed by a LDSS designated agency (e.g. Certified Home Health Agency, Developmental Disabilities Services Organization, or Community Alternative Systems Agency) to complete an assessment and a Pediatric Patient Review Instrument (PPRI) for each applicant.

The assessment (initial and every six months after enrollment) takes into account the applicant's medical, social, habilitation and environmental needs, as well as the family's needs, strengths and abilities.

The assessment also identifies all informal caregivers who are trained and available to provide skilled care for the child, including notation of their schedules and an adequate back-up plan in the absence of skilled homecare professionals. Documentation must clearly indicate that informal caregivers have been trained in the child's care or, if they are currently engaged in training, who is providing the training and when it is anticipated that the training will be complete. The assessment must clearly indicate findings based on evaluation, documented need and clearly identified interventions.

The PPRI is used to ascertain that the applicant needs skilled nursing facility or hospital level of care as required for participation in CAH I/II, and that the medical interventions are necessary for the child to be safely cared for at home. The PPRI must be signed by the assessing RN.

During all steps of the assessment process, the LDSS CAH I/II coordinator and case manager remain in contact with the waiver applicant's parents/legal guardians. Case management activities related to assessment also include: scheduling the assessment to accommodate the parent's schedule, serving as a conduit for the family to obtain information and knowledge about the CAH I/II waiver, informing the family of the choice of providers available to render the services, and assisting the family to access knowledge about their child's medical condition and outside supports in the community

The CAH I/II case manager forwards the assessment results and the PPRI to the applicant's physician. The physician reviews the information and the case manager's recommendations, and is responsible for authorizing the services (including the provider skill, frequency, duration) necessary to maintain the applicant in the community.

Service Plan

The LDSS CAH I/II coordinator reviews all documentation to determine waiver eligibility and provides copies of the assessment, PPRI and physician orders to the CAH I/II case manager in accordance NYSDOH policy guidance (04 OMM LCM-2).

The CAH I/II case manager, with the assistance and input from the child's parent(s)/legal guardian(s), uses the assessment, the PPRI, and physician orders to design a Plan of Care that will:
• Identify CAH I/II waiver and State Plan services needed to meet the participant's community based needs;
• Identify available informal caregivers and other resources necessary to the appropriate and safe care of the child in the home;
• Ensure conformance with waiver program policies;
• Address service delivery issues;
• Verify provision of provider choice has been offered to the participant and/or parents/legal guardian; and
• Note schedule for required updates.

The CAH I/II case manager's recommendations for services and providers are recorded on the Case Management Plan of Services form signed by the CAH I/II case manager and the participant's parent(s)/legal guardian. The LDSS CAH I/II coordinator reviews the proposed Plan of Care, including the CAH I/II case manager's recommendations, and determines an applicant's appropriateness for CAH I/II participation.

Once the LDSS coordinator has completed the required enrollment activities, the Plan of Care, with supporting documentation, is forwarded to NYSDOH waiver management staff for review. Upon review of the documentation, the NYSDOH waiver management staff send a letter to the LDSS CAH I/II coordinator accepting or denying their request for an applicant's enrollment in the CAH I/II waiver.

Plan of Care Update

The assessment must be updated every six months to clearly reflect the current needs of the child that can be met only through the CAH I/II waiver services (case management, respite, home and/or vehicle modification, palliative services), and other medically necessary MA State Plan services.

The Plan of Care is subsequently revised by the CAH I/II case manager to reflect any change in care identified by the assessment. The updated Plan of Care is then forwarded to the LDSS CAH I/II coordinator for review and approval.

The PPRI is updated and submitted to LDSS CAH I/II coordinator annually by the CAH I/II case manager.

Physician orders are required to be renewed every sixty days and are submitted to the LDSS CAH I/II coordinator and the CAH I/II case manager.

Change in the participant's medical condition may require more frequent assessments of the child's needs and revision of all or part of their Plan of Care to authorize necessary interventions for the child and family. The revised plan must be signed and dated by the CAH I/II case manager and the participant's parents/legal guardian.

Case Records Maintenance

The original approved and signed Plan of Care is maintained in the applicant's case file by the LDSS CAH I/II

coordinator. A copy of the approved Plan of Care is maintained by the NYSDOH waiver management staff.

Any subsequent approved revision of a participant's Plan of Care requires the participant's parent(s)/legal guardian's signature. Copies of all amended Plans of Care are kept in the participant's LDSS case file and made accessible to NYSDOH as needed.

A copy of the participant's approved original Plan of Care and subsequent amendments are given to the participant and/or their parents/legal guardian.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Since CAH I/II participants are under the age of eighteen and live at home with their parents, the needs of the family as whole must be taken into account when developing the child's plan of care. The caregiver back-up plan, schedule and availability of the informal caregivers (parents/legal guardian) are reflected in the plan of care and affect the number of hours of skilled care that may be required.

Safety is essential to successful waiver participant and is a key consideration in plan of care development. All plans of care must demonstrate that the participant can be cared for in the home and able to safely access the community services. The assessment and plan of care must address necessary home modifications, vehicle adaptations, and/or durable medical equipment that will benefit the waiver participant and allow caregivers to provide services for the child safely.

The plan of care is reviewed every six months. Physician's orders are updated every 60 days. In the interim, any changes needed in the plan of care to assure the safety of the participant may be brought to the attention of the LDSS by the CAH case manager or other caregiver. The LDSS coordinator oversees the implementation of any change to the waiver participant's plan of care.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The LDSS must offer all applicants/participant's the choice of available services and providers. The LDSS is responsible for making sure that wavier applicants/participants and their parents/legal guardians know of their child's right to choose and change service providers, and that the LDSS CAH I/II coordinator will assist the participant in doing so.

The LDSS is also required to provide all applicants/participants with verbal and written notice of their rights under Medicaid.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The LDSS CAH I/II coordinator reviews and approves all plans of care. Once the initial plan of care is developed for the applicant, the LDSS makes a determination as to waiver enrollment. The LDSS CAH I/II coordinator then sends the documentation and enrollment recommendation to NYSDOH for review. NYSDOH waiver management staff review the information and notify the LDSS if they are in agreement with the enrollment recommendations. NYSDOH will maintain communication with the LDSS until resolution of any questions or concerns regarding the provision of procedures and/or necessary services to maintain the applicant at home.

NYSDOH waiver management staff are routinely in contact with the LDSS CAH I/II coordinator, case managers, families and providers regarding waiver applicants and services rendered to the waiver participant. NYSDOH waiver management staff monitor plans of care that must include all necessary supporting documentation. If corrective actions are indicated, NYSDOH will notify the LDSS in writing as to the actions necessary to remediate the situation. NYSDOH will also evaluate the documentation from the plans of care against claim data acquired through eMEDNY to assure that services have been appropriately delivered in accordance with the approved plan of care. (For description of eMEDNY, see section I-1)

The LDSS CAH I/II coordinator can request adjustments to the plan of care, either at time of application, at the six month reassessment or any time during the review period when they determine that the proposed or implemented service plan is not meeting the needs of the applicant/wavier participant. If the necessary parties (MD, assessing agency, and applicant/parent) can not agree, the LDSS Medical Professional Director will review case documentation and take action to resolve the situation. NYSDOH waiver management staff provide technical and professional assistance to the LDSS as needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ■ **Every three months or more frequently when necessary**
- ■ **Every six months or more frequently when necessary**
- ■ **Every twelve months or more frequently when necessary**
- ■ **Other schedule**

Specify the other schedule:

Physician orders every 60 days.

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

The LDSS CAH coordinator and the CAH case management agency maintian particpant service plans.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

In addition to reviewing and approving each plan of care, the LDSS CAH I/II coordinator continually monitors the plan of care and maintains contact with the waiver applicants and their parents/legal guardians, waiver providers and NYSDOH waiver management staff. Issues identified by the LDSS staff are addressed by them directly or referred to NYSDOH waiver management staff for review and recommendations. The waiver participant/parents may contact the LDSS CAH I/II coordinator or NYSDOH waiver management staff at any time to discuss issues. Information about this process is relayed to all waiver applicant families and is available in hard copy and on-line in the "CAH Handbook for Parents".

Any discrepancies between the plan of care and actual delivered services are identified through a range of methods including a retrospective plan of care review, a retrospective paid claims review, provider surveillance, and/or information received by the LDSS and/or NYSDOH waiver management staff. When problems are identified, further investigation is begun by an on-site visit to the LDSS or provider, or through formal referral to the appropriate agency for audit and review.

On a routine basis, NYSDOH waiver management staff monitor the program. Random review of cases are conducted by comparing paid claims to services authorized in the plan of care and parents of the participant are asked to certify that certain waiver services were provided and completed in accordance with an approved agreement. Every waiver participant must have a recipient restriction/exception (R/E) code on their Medicaid enrollment file that identifies the child as a CAH I/II waiver participant. The LDSS is responsible for putting the CAH I/II R/E code and effective date on the applicant's WMS file.

Waiver service delivery is also monitored through participant feedback, such as the recent survey of waiver participants' parents to gather input about their experiences in the waiver program.

When NYSDOH conducts a random review of all CAH I/II cases, the LDSS is notified in writing of any deficiencies and a corrective plan is noted. Depending upon the findings, corrective action may be required immediately or within the next re-assessment period as appropriate. If issues are noted by the LDSS CAH I/II coordinator, NYSDOH or another oversight agency, in conjunction with the LDSS, will conduct a case review including service plans, paid claims, and other documentation from waiver participants/parents. Written reports, and correction plans if necessary, may be required. If it is found that services continue to be out of keeping with the participant's service plan or out of compliance with State and federal regulations, NYSDOH may take steps to terminate the provider's enrollment status.

b. Monitoring Safeguards. *Select one:*

■ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

■ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory

assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of Plans of Care that address the participants' assessed needs, as noted on the assessment tools, through the provision of waiver and State Plan services or other resources.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of all waiver participant case files that have a case management services form listing the needs identified through assessment and authorized by the physician.

Data Source (Select one):
Other
If 'Other' is selected, specify:
on-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of Plans of Care developed in accordance with waiver policy and procedures.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☑ **Other** Specify: LDSS CAH I/II Coordinator	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: LDSS CAH I/II Coordinator	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of waiver participant Plans of Care, verified though a sample case review by NYSDOH staff, that contains physician orders that have been updated every 60 days, a LDSS representative signature on the participant assessment form, and a participant's parent/legal guardian's signature on the case management services form.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% annual sample review
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: LDSS CAH I/II Coordinator	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance

measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of Plans of Care that are updated every six months or when warranted by a change in the participant's needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of waiver participant Plans of Care that include physician's orders that have been updated/revised every 60 days.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% annual review and as deemed necessary
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of services that are delivered in accordance with the Plan of Care including type, amount, scope, duration and frequency as specified in the authorized plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of waiver participants who have paid claim(s) reflecting compliance with their approved Plan of Care.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% annual review and as deemed necessary
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory

assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of participants offered a choice between waiver services and institutional care, and a choice among waiver services and providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of waiver participant Plans of Care that have a completed Choice of Care Form and Case Management Selection form in the participant's case file.

Data Source (Select one):
Other
If 'Other' is selected, specify:
on-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% annual review and as deemed necessary
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DOH monitors certain waiver providers that operate in New York State by standard periodic inspections that include state licensure surveys, federal initial certification surveys and recertification surveys to ensure the agency meets all governing federal (Medicaid) and State guidelines. All significant issues/deficiencies identified during such survey, or by other complaint, must be shared with NYSDOH waiver management staff. Uncorrected deficiencies findings may jeopardize the provider's ability to provide services under the waiver.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The remediation process is initiated when the LDSS CAH I/II coordinator or NYSDOH waiver management staff identify a lack in the quality of provided services, or any other issue related to administration of CAH I/II.

In such situations, the standard procedure is for NYSDOH waiver management staff and the LDSS CAH I/II coordinator to discuss the situation and collaboratively develop a plan of correction. Implementation and compliance with the plan of correction is monitored by NYSDOH and LDSS staff.

Should the plan of correction require a change in the participant's service, the NYSDOH waiver management staff and the LDSS CAH I/II coordinator will work cooperatively to address the service deficiency and when necessary, transition the child to another CAH I/II provider. To ensure continuity of service during the transition period, the original provider will be required to transfer the CAH I/II participant case records and other pertinent documents to the new provider.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide CAH I/II services. Accordingly, NYSDOH waiver management staff will issue a letter to the provider terminating their

CAH I/II waiver provider status.

Unsatisfactory home and vehicle modification contractors will be notified of their disqualification from further service by the administering LDSS. The LDSS CAH I/II coordinator will help the family find alternate contractors and craftsmen.

Documentation of remediation activities is accomplished by the following measures: correspondence between NYSDOH waiver management staff, the LDSS CAH I/II coordinator, participants' and their parents/legal guardians, and/or service providers; amended plans of care; LDSS case reviews and reports of follow-up meetings with participants and their families; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file and, as appropriate, by NYSDOH/OLTC.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: LDSS CAH I/II Coordinator	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

■ **No**

■ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

■ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

■ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to

participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

■ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The CAH I/II waiver applicant/participant is informed of his/her fair hearing rights at the time of application for Medicaid benefits. The Medicaid application includes information for the applicant regarding their general Medicaid rights.

The LDSS must give the CAH I/II waiver applicant/participant adequate and timely notice when approving or denying waiver applications and/or when terminating a waiver participant's benefits. The Notice of Decision form includes instruction as to how to exercise the right to an agency conference and fair hearings.

To assure statewide uniformity, NYSDOH has advised the LDSS about CAH I/II fair hearing procedures and related official forms in NYSDOH Administrative Directive 04 OMM\ADM-1.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ■ **No. This Appendix does not apply**
- ■ **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description

are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- **No. This Appendix does not apply**
- **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

The New York State Department of Health (NYSDOH)does not have a specific Critical Event or Incident Reporting process for CAH I/II. However, there is a process in place to elicit information on the health and welfare of individuals served through the program and for reporting incidences of abuse, neglect, exploitation, or other concerns.

At a minimum, the CAH I/II case manager must maintain monthly contact with the waiver participant and their family. Contacts may occur in the child's home, school, or other appropriate location. The purpose of the contact is to provide ongoing support, advocacy and follow-up to assure appropriate service delivery for the child and family and serve as a vehicle to complete the six month assessment requirement for the waiver program. During these contacts, possible abuse, neglect and exploitation may be identified, documented and referred to the appropriate entity for resolution.

CAH I/II waiver participants reside in the community in the home of the parent/guardian, who has legal

responsiblity for them, and attend school or other public activities where legally mandated reporters and/or other concerned persons can notice and report breakdowns in their care. For instance, under Section 413 of the NYS Social Service Law, nurses are named as mandated reporters who have a legal obligation to report abuse or neglect. Enactment of "Xctasy's Law" included Local Department Social Service (LDSS) workers as legally mandated reporters.

NYS has other supports in place, such as the statewide Child Abuse Hotline, to assist parents/guardians, teachers and social service workers report concerns for a child's health and safety. (For additional information see: the Quality Improvement: Health and Welfare section a Methods for Discovery).

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

■ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

CAH I/II participants live at home with their parent/legal guardian who have primary legal responsibility for their health and welfare. The LDSS CAH I/II coordinator takes reports about use of restraint or seclusion from parents or other staff. The LDSS Child Protective Services staff investigates and takes any necessary actions.

■ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

■ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Any staff person or family member who observes a use of restraint must report it immediately according to agency protocol.

■ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**

Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

■ **No. This Appendix is not applicable** *(do not complete the remaining items)*

■ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

■ **Not applicable.** *(do not complete the remaining items)*

■ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

■ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

■ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and type of incidents reported by LDSS CAH I/II Coordinator, CAH I/II Case Manager, Physician or any other voluntary source noted in the participant's case file or through correspondance with other NYSDOH waiver management staff as appropriate.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: LDSS and other NYS responsible entities.	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: LDSS CAH I/II coordinators Other sources	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Minimum of six months

Performance Measure:
The number and percent of physician order renewals that are completed by the physician and reviewed and maintained by the LDSS CAH I/II coordinator and are available at the request of the NYSDOH.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% annual review and as deemed necessary
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

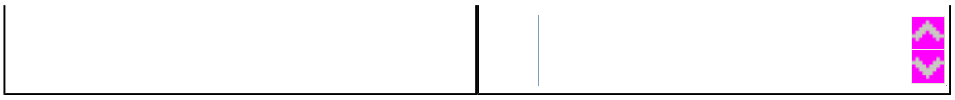
The number and percent of case reviews that substantiate successful compliance with all requirements to prevent abuse, neglect and exploitation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% annual
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:



ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The protection of waiver participants' health and welfare begins at the local level with the LDSS Child Protective Services Unit (CPS). The New York State Office of Children and Family Services maintains a statewide Central Register of Child Abuse and Maltreatment for reports made pursuant to New York State Social Services Law. The local CPS Unit is required to investigate reports to protect children from further abuse or maltreatment, and to provide rehabilitative services to children, parents, and other family members.

The CAH I/II case manager contacts the waiver participant's family at a minimum, on a monthly basis. The contact may occur in the child's home or at another location such as the child's school. The purpose of the contact is to provide ongoing support, advocacy and follow-up for the child and family, including identifying possible abuse, neglect, or exploitation. If one of these problems is identified, it is then documented and referred to the appropriate entity. These meetings also serve as a vehicle to complete the six month assessment requirement for the waiver program.

A physician must review the current medical situation of the participant which may reveal necessary changes in the child's continued safe treatment in the community. Orders are completed and renewed every sixty days and when ever there is a change in the child's medical needs. The orders must be signed by the physician, indicating the type, frequency and duration of skilled home care, treatments and medications and any other necessary services that reflect skilled home care needs.

NYSDOH waiver management staff routinely discuss efforts to prevent abuse, neglect and exploitation with the LDSS CAH I/II coordinators during quarterly statewide conference calls. The aim is to develop enhanced and consistent statewide incident reporting and documentation processes. NYSDOH/OLTC staff also work with the staff of the LDSS Child Teen Health Program, NYS's federally mandated Early Periodic Screening Program, Diagnosis and Treatment Program, and the Office of Children and Family Services to provide CAH I/II participants and their parents/legal guardians with information about mandated incident reporting policies.

NYSDOH/OLTC also require NYSDOH CAH I/II waiver management staff to be copied on any correspondence that concerns a provider of services for a CAH I/II participant; whether it be a response to a LDSS CAH I/II coordinator, a parent/guardian who has made a complaint, or an investigation of a provider requested by another agency.

Finally NYSDOH waiver management staff performs an annual ten percent case review and evaluation. If any patterns of error are identified, or greater than fifteen percent of reviewed cases are found to be "unsatisfactory", the NYSDOH will take action in the form of further inquiry, assessment of a need for training and/or further evaluation of the CAH I/II administrative system (including the protocol and performance of the CAH I/II Case manager and LDSS CAH I/II coordinator). These systemic measures have the underlying purpose of preventing abuse, neglect and exploitation of those in the CAH I/II waiver.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The remediation process is initiated when the LDSS CAH I/II coordinator or NYSDOH waiver management staff identify a lack in the quality of provided services, or any other issue related to administration of CAH I/II.

In such situations, the standard procedure is for NYSDOH waiver management staff and the LDSS CAH I/II coordinator to discuss the situation and collaboratively develop a plan of corrective action. Implementation and compliance with the plan of correction is monitored by NYSDOH and LDSS staff.

Should the plan of correction require a change in the participant's service, the NYSDOH waiver management staff and the LDSS CAH I/II coordinator will work cooperatively to address the service deficiency and when necessary, transition the child to another CAH I/II provider. To ensure continuity of service during the

transition period, the original provider will be required to transfer the CAH I/II participant case records and other pertinent documents to the new provider.

Remediation of financial issues begins immediately upon the discovery of any impropriety. The NYSDOH waiver management staff, and other Department staff as appropriate, will immediately initiate remediation of any inappropriate claims processed through eMedNY. Remediation may include voiding payments, assigning penalties and sanctioning providers. In the case of home and vehicle modifications, LDSS staff will initiate remediation by cancelling payments to home and vehicle contractors. The LDSS staff will initiate remediation of any inappropriate claims processed on Schedule E.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide CAH I/II services. Accordingly, NYSDOH waiver management staff will issue a letter to the provider terminating their CAH I/II waiver provider status.

Unsatisfactory home and vehicle modification contractors will be notified of their disqualification from further service by the administering LDSS. The LDSS CAH I/II coordinator will help the family find alternate contractors and craftsmen.

Documentation of remediation activities is accomplished by the following measures: correspondence between NYSDOH waiver management staff, the LDSS CAH I/II coordinator, participants' and their parents/legal guardians, and/or service providers; amended plans of care; LDSS case reviews and reports of follow-up meetings with participants and their families; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file and, as appropriate, by NYSDOH/OLTC.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: As needed

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

■ **No**

■ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Since the last renewal of the waiver, NYSDOH has reorganized its long term care (LTC) functions. This has provided multiple advantages for QA/QI activities. First, the State's 1915(c) waivers serving the long term care needs of Medicaid consumers are all under the management of the Deputy Commissioner for the Office of Long Term Care (Traumatic Brain Injury, Nursing Home Transition Diversion, Care at Home, Bridges To Health, and Long Term Home Health Care Program). This facilitates cross waiver analysis, policy development and systems change, allowing comparison of identified problems, solutions, and best policies. Second, it permits better integration of QA/QI waiver initiatives with these pursued for State Plan long term care services. For example, the Department's initiative to develop a uniform data set for LTC will inform QA/QI analysis and service improvement activities regardless of payer, to the general public, as well as Medicaid State Plan and 1915(c) services.

Typically, NYSDOH/OLTC implements system design change to MA waiver programs when there is a clear and strong need has been identified by State and/or local waiver management staff or other stakeholders.

Stakeholders have several vehicles with which to voice their concerns, including regional meetings, stakeholder surveys, contact with their LDSS CAH I/II coordinators, and direct communication with NYSDOH waiver management staff. Discovery efforts are completed and remediation actions taken. Should the agreed upon remedies not be a satisfactory resolution, further study of the particular waiver element is undertaken. The recommendations of NYSDOH staff, waiver participants, providers and other stakeholders are considered.

Position papers are written summarizing the findings and analysis and presented to senior NYSDOH managers. Recommendations are prioritized by OLTC Executive staff in consultation with the State Medicaid Director on the basis of the scope of the policy, its impact on waiver participants, and the overall ability of the State to accommodate any fiscal impact. Subsequent recommendations are approved in keeping with programmatic priorities, consumer benefit, and the opportunity for administrative efficiency and system wide reform.

If the system change is accepted but cannot be made administratively, certain measures are recommended and implemented though the established annual NYS budget and legislative process. At this stage, OLTC staff brief NYS Division of the Budget and Legislative staff, and discuss the proposals with program participants, advocates, providers, and other stakeholders to gain their input and support.

Waiver management staff implement system change when authorized by the NYSDOH and Medicaid Director.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: LDSS CAH I/II Coordinators	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The State collects, monitors and analyzes feedback regarding system design changes using several different methods. The participant survey method is used to gauge the effectiveness of the CAH I/II waiver program by asking for the input of those who use the waiver's services. The LDSS and NYSDOH/OLTC staff record and gather responses to system changes in the waiver by contacting and meeting with parents, advocate groups, providers and other stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The quality improvement (QA/QI) strategies are reevaluated on an annual basis and whenever areas of improvement can be identified and quickly corrected. Post assessments of QA/QI initiatives are used to reveal areas for improvement and update of the CAH I/II program.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

NYSDOH is the single state agency responsible for monitoring and auditing payments made under the New York State Medicaid (MA) program. Statewide audits of Medicaid funded programs are conducted by the Office of State Comptroller (OSC); the Office of the Attorney General (AG); and the NYSDOH Office of Medicaid Inspector General (OMIG). In addition, the Medicaid agency and the LDSS also conduct reviews and audits of MA funded programs.

A periodic independent audit of the CAH I/II waiver is conducted by New York State. In compliance with the Single Audit Act, New York State contracts with a private Certified Public Accounting (CPA) firm to complete an annual audit of all major federal programs in New York State. The audit work is determined by a risk analysis of the programs, and therefore can vary from year to year.

New York State maintains an electronic Medicaid (MA) system, eMedNY, through which providers submit claims and receive payments for MA covered services provided to eligible clients. In addition to the adjudication and payment of claims, the eMedNY system includes eligibility verification and a Medicaid Data Warehouse for the review and analysis of MA related data. The system replaced the former Medicaid Management Information System (MMIS).

All MA services adjudicated and reimbursed through eMedNY are subject to independent audit directed at ensuring provider compliance with applicable laws, regulations and policies as set forth by the Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York, provider guidelines and billing policy found in eMEDNY provider manuals, and other provider billing directives issued by NYSDOH.

Providers are targeted for audit via the eMedNY Data WareHouse, monitoring activities, and provider profiling used to identify claiming patterns that appear suspicious or aberrant. The NYSDOH waiver management staff and/or the LDSS may also recommend providers to be reviewed and audited. The frequency of audits of waiver providers will be determined by OMIG.

Pursuant to Chapter 405 of the Laws of 1999, the Office of the State Comptroller engages a CPA to perform an Independent annual audit of the State of New York's financial statements prepared by the State Comptroller. In conjunction with the audit, the CPA contacts NYSDOH to discuss various financial systems related to our information technology control environment, and obtains information and supporting documentation needed to corroborate the amount claimed and inquire about other matters related to the financial statement audit.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of claims for waiver services adjudicated through eMEDNY that can be identified as being billed by a enrolled waiver provider, and the recipient of services can be identified correctly as a participant in the waiver at the time of service delivery.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and central desk review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The remediation process is initiated when the LDSS CAH I/II coordinator or NYSDOH waiver management staff identify a lack in the quality of provided services, or any other issue related to administration of CAH I/II.

In such situations, the standard procedure is for NYSDOH waiver management staff and the LDSS CAH I/II coordinator to discuss the situation and collaboratively develop a plan of correction. Implementation and compliance with the plan of correction is monitored by NYSDOH and LDSS staff.

Should the plan of correction require a change in the participant's service, the NYSDOH waiver management staff and the LDSS CAH I/II coordinator will work cooperatively to address the service deficiency and when necessary, transition the child to another CAH I/II provider. To ensure continuity of service during the transition period, the original provider will be required to transfer the CAH I/II participant case records and other pertinent documents to the new provider.

Remediation of financial issues begins immediately upon the discovery of any impropriety. The NYSDOH waiver management staff, and other Department staff as appropriate, will immediately initiate remediation of any inappropriate claims processed through eMedNY. Remediation may include voiding payments, assigning penalties and sanctioning providers. In the case of home and vehicle modifications, LDSS staff will initiate remediation by cancelling payments to home and vehicle contractors. The LDSS staff will initiate remediation of any inappropriate claims processed on Schedule E.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide CAH I/II services. Accordingly, NYSDOH waiver management staff will issue a letter to the provider terminating their CAH I/II waiver provider status.

Unsatisfactory home and vehicle modification contractors will be notified of their disqualification from further service by the administering LDSS. The LDSS CAH I/II coordinator will help the family find alternate contractors and craftsmen.

Documentation of remediation activities is accomplished by the following measures: correspondence between NYSDOH waiver management staff, the LDSS CAH I/II coordinator, participants' and their parents/legal guardians, and/or service providers; amended plans of care; LDSS case reviews and reports of follow-up meetings with participants and their families; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file and, as appropriate, by NYSDOH/OLTC.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

■ **No**

■ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

There are several methods used to determine provider reimbursement rates sufficient to attract a substantial number of qualified providers for the various CAH I/II waiver services. Services, with the exception of home and vehicle modifications; are paid according to a single statewide amount. Case Management services are reimbursed according to a single statewide fee developed by NYSDOH rate setters and approved by the NYS Division of the Budget (DOB).

Respite Service rates are developed by NYSDOH rate setters, approved by the DOB, and assigned to each

provider. Palliative care services (family training, pain and symptom management, bereavement, expressive therapies, and massage therapy) are being developed by NYSDOH rate setters subject to DOB approval. Home and vehicle modification reimbursement is based on a bid process which takes into consideration local market conditions, skill needed to complete the project, the type of project and location of the child's home.

NYSDOH gives public notice required by the State Administrative Procedure Act (SAPA) and other State Laws of any amendment to its regulations regarding the rate-setting methodology. SAPA requires that a Notice of Proposed Rulemaking include a name, public office address and telephone number for an agency representative to whom written views and arguments may be submitted. It should be noted that NYSDOH has not changed the method for determining waiver service payments.

If parents/guardians of CAH I/II participants have any questions about the payment rates made to the agencies, they may contact the LDSS, their case manager or the DOH Public Affairs Office to obtain this information.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The majority of waiver services are delivered by enrolled providers who bill directly to eMedNY, either by paper claim or electronic submission. The Medicaid provider is responsible to ensure the accuracy of information, such as date of service and recipient MA identification prior to submitting claims. The eMedNY system will adjudicate the claim, and payment will be issued directly to the provider.

In those limited instances where case management services are provided by an entity other than an enrolled provider, the services may be funded through the NYSDOH administrative claiming processes.

Home and vehicle modifications do not result in a claim to eMedNY, primarily because of the present impracticality due to low annual utilization rates and project variations. Instead, NYS utilizes a vendor bid process for home and vehicle modifications and payments are made on to the provider by the LDSS. The LDSS in turn, bills the NYSDOH using the established District claiming procedures (Schedule E). See Appendix I-3 g-I for voluntary reassignment of payments for additional information.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

■ **No. State or local government agencies do not certify expenditures for waiver services.**

■ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b)

how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All billings are processed either through eMedNY or through the Schedule E system and will be subjected to eligibility and payment edits.

For waiver services adjudicated through eMedNY, CAH I/II participants' eligibility for the waiver services on the date of the claim is verified through payment system edits. For home and vehicle modifications, the responsible LDSS verifies: participants' eligibility for the waiver services on the date of the claim, date of service delivery, plan of care identification as an authorized service, and physician order for the modification project as medically necessary.

For home modifications and vehicle adaptations, LDSS staff, evaluator, or/and case manager verify the completion of the home or vehicle modification prior to final contract payment. In addition, the parent/legal guardian of the participant signs a statement indicating that the work has been satisfactorily completed in accordance with Administrative Directive for Home Adaptation and Vehicle Modification ADM 00 OMMADM-4. A copy of the statement is maintained as part of the case file and a copy is forwarded to NYSDOH waiver management staff.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- ■ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ■ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

For home and vehicle modifications paid via Schedule E, the LDSS verifies the child's eligibility and makes a partial payment to the contractor at outset of the project. The LDSS makes the final contract payment when it determines that the project has been completed as identified in the recipient's plan of care and receives the parent's signoff that the work has been completed satisfactorily. LDSS reports these expenditures on Schedule E in accordance with the NYS Fiscal Reference Manual. Schedule E has a dedicated line, line 20, which the LDSS uses to report CAH home and vehicle modification waiver expenditures. The LDSS also authorizes these expenditures in the Welfare Management System (WMS) with a pay type of P9 and special claiming categories

of V for federally participating, R for federally non-participating, and N for Non-Reimbursable. These expenditures are then entered in the State's Automated Claims System which is used to generate the quarterly CMS-64 report. Data to support the Schedule E claim is maintained at the LDSS for annual DOH review and audit purposes. In addition, home and vehicle modifications are reviewed as part of the NYSDOH annual sample reviews of cases.

■ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

■ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- **No. The State does not make supplemental or enhanced payments for waiver services.**
- **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Publically operated CHHA providers of Palliative Care services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs**

of providing waiver services.

■ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

■ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

■ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

■ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

■ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

Home and Vehicle modification is the only CAH I/II service for which payments are reassigned. Vendors are required to sign a Statement of Reassignment that they will only bill the LDSS for the adaptation specified in the child's approved plan and accept the agreed amount as payment in full. Furthermore, the vendor acknowledges that the LDSS will request MA reimbursement via Schedule E, on behalf of the vendor, and retain any reimbursement obtained for these services. This process is specified in ADM 00 OMMADM-4.

ii. Organized Health Care Delivery System. *Select one:*

■ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements**

under the provisions of 42 CFR §447.10.

■ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

■ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

■ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

■ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The General Fund (state tax revenue supported) state share for Medicaid is also appropriated in the NYS Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Children and Family Services, Office of Alcoholism and Substance Abuse Services, and State Education

Department budgets. Funds are transferred from these agencies, upon approval from the NYS Director of Budget, to the NYS Department of Health (NYSDOH) using the certificate of approval process (funding control mechanism specified in the State Finance Law, or through journal transfers).

☑ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Medicaid State share is also provided through appropriations in NYSDOH for funds (net of any federal share) received from drug rebates, audit recoveries and refunds, and third party recoveries; assessments on nursing home and hospital gross revenue receipts; and Health Care Reform Act (HCRA) revenues. Appropriations in OMRDD for the Mental Hygiene Patient Income Account and in OMH for HCRA also fund the state share of Medicaid and are transferred to NYSDOH.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

■ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

■ **Applicable**

Check each that applies:

☑ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Counties in New York State and the City of New York have the authority to levy taxes and other revenues. These local entities may raise revenue in a variety of ways including taxes, surcharges and user fees. The State, through a state/county agreement, has an established system by which local entities are notified at regular intervals of the local share of Medicaid expenditures for those individuals for which they are fiscally responsible. In turn, the local entities remit payment of these expenditures directly to the State.

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b

that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- **The following source(s) are used**

  Check each that applies:
  - **Health care-related taxes or fees**
  - **Provider-related donations**
  - **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

■ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

■ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	7413.00	129851.95	137264.95	123498.89	21089.16	144588.05	7323.10
2	7410.00	132708.69	140118.69	126215.86	21553.13	147768.99	7650.30
3	7410.00	135628.29	143038.29	128992.61	22027.29	151019.90	7981.61
4	7410.00	138612.11	146022.11	131830.45	22511.89	154342.34	8320.23
5	7410.00	141661.57	149071.57	134730.72	23007.16	157737.88	8666.31

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Hospital	Level of Care: Nursing Facility
Year 1	2292	917	1375
Year 2	3698	1479	2219
Year 3	3698	1479	2219
Year 4 (renewal only)	3698	1479	2219
Year 5 (renewal only)	3698	1479	2219

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Determine begin date and end date for each recipient.
Calculate total annual days by take a difference between begin date and end data for each recipient, and aggregate individual total days to get total annual days for the entire population.
Divide total annual days for the entire population by the number of total recipients.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D values are derived from the estimated unit cost of each waiver service based on established payment rates, the number of units of service expected to be delivered annually, multiplied the number of participants expected to receive to each service. In the instance of the new palliative care services, reimbursement amounts were estimated, pending finalization of the rate setting process, based on the cost of similar services included in NYS Hospice payment rate, comparability with the proposed reimbursement level included in palliative care waiver applications of other States, and the research and recommendation of the NYS stakeholders who participated in the planning for the new services.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D’ values are derived from the most recent NYS CAH I/II 372s report, waiver period 12/1/05-11/30/06, approved by CMS. This report includes all MA State Plan service costs, including any institutional or other care received by CAH I/II waiver participants. For the waiver renewal years, the 2005-06 values were trended forward using NYS authorized trend factors for nursing home and hospital costs, 2.2 and 7.11 percent

respectively.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G values were estimated using NYS actual expenditure data for nursing home and hospital care of child Medicaid recipients of the same age as comparable CAH I/II participants for dates of service during the 2005-06 waiver year. This information is generated from the eMedNY, AFPP Data Mart Claims system. [See Appendix I-1 for description of the eMedNY system.]

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' values were estimated by using NYS actual expenditure data for all non-institutional MA State Plan services for the same Medicaid recipient group as for Factor G for dates of service during the 2005-06 waiver year. This information is generated from the eMedNY AFPP Data Mart Claims system.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Case Management
Bereavement Services
Expressive Therapies
Family Palliative Care Education (Training)
Home and Vehicle Modification
Massage Therapy
Pain and Symptom Management
Respite

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**12586080.00**
Case Management	Hour	2017	78.00	80.00	**12586080.00**	
Bereavement Services Total:						**282880.00**

Bereavement Services	Hour	136	52.00	40.00	**282880.00**	
Expressive Therapies Total:						**282880.00**
Expressive Therapies	Hour	136	52.00	40.00	**282880.00**	
Family Palliative Care Education (Training) Total:						**565760.00**
Family Palliative Care Education (Training)	Hour	136	104.00	40.00	**565760.00**	
Home and Vehicle Modification Total:						**2760000.00**
Home and Vehicle Modification	Project	230	1.00	12000.00	**2760000.00**	
Massage Therapy Total:						**141440.00**
Massage Therapy	Hour	136	26.00	40.00	**141440.00**	
Pain and Symptom Management Total:						**141440.00**
Pain and Symptom Management	Hour	136	26.00	40.00	**141440.00**	
Respite Total:						**230000.00**
Respite	Day	230	4.00	250.00	**230000.00**	

GRAND TOTAL:	**16990480.00**
Total Estimated Unduplicated Participants:	**2292**
Factor D (Divide total by number of participants):	**7413.00**
Average Length of Stay on the Waiver:	322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**20304960.00**
Case Management	Hour	3254	78.00	80.00	**20304960.00**	
Bereavement Services Total:						**457600.00**
Bereavement Services	Hour	220	52.00	40.00	**457600.00**	
Expressive Therapies Total:						**457600.00**
Expressive Therapies	Hour	220	52.00	40.00	**457600.00**	
Family Palliative Care						

Education (Training) Total:						**915200.00**
Family Palliative Care Education (Training)	Hour	220	104.00	40.00	**915200.00**	
Home and Vehicle Modification Total:						**4440000.00**
Home and Vehicle Modification	Project	370	1.00	12000.00	**4440000.00**	
Massage Therapy Total:						**228800.00**
Massage Therapy	Hour	220	26.00	40.00	**228800.00**	
Pain and Symptom Management Total:						**228800.00**
Pain and Symptom Management	Hour	220	26.00	40.00	**228800.00**	
Respite Total:						**370000.00**
Respite	Day	370	4.00	250.00	**370000.00**	

GRAND TOTAL:	**27402960.00**
Total Estimated Unduplicated Participants:	**3698**
Factor D (Divide total by number of participants):	**7410.00**
Average Length of Stay on the Waiver:	322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**20304960.00**
Case Management	Hour	3254	78.00	80.00	**20304960.00**	
Bereavement Services Total:						**457600.00**
Bereavement Services	Hour	220	52.00	40.00	**457600.00**	
Expressive Therapies Total:						**457600.00**
Expressive Therapies	Hour	220	52.00	40.00	**457600.00**	
Family Palliative Care Education (Training) Total:						**915200.00**
Family Palliative Care Education (Training)	Hour	220	104.00	40.00	**915200.00**	
Home and Vehicle Modification Total:						**4440000.00**
Home and Vehicle						

Modification	Project	370	1.00	12000.00	**4440000.00**	
Massage Therapy Total:						**228800.00**
Massage Therapy	Hour	220	26.00	40.00	**228800.00**	
Pain and Symptom Management Total:						**228800.00**
Pain and Symptom Management	Hour	220	26.00	40.00	**228800.00**	
Respite Total:						**370000.00**
Respite	Day	370	4.00	250.00	**370000.00**	

GRAND TOTAL:	**27402960.00**
Total Estimated Unduplicated Participants:	**3698**
Factor D (Divide total by number of participants):	**7410.00**
Average Length of Stay on the Waiver:	322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**20304960.00**
Case Management	Hour	3254	78.00	80.00	**20304960.00**	
Bereavement Services Total:						**457600.00**
Bereavement Services	Hour	220	52.00	40.00	**457600.00**	
Expressive Therapies Total:						**457600.00**
Expressive Therapies	Hour	220	52.00	40.00	**457600.00**	
Family Palliative Care Education (Training) Total:						**915200.00**
Family Palliative Care Education (Training)	Hour	220	104.00	40.00	**915200.00**	
Home and Vehicle Modification Total:						**4440000.00**
Home and Vehicle Modification	Project	370	1.00	12000.00	**4440000.00**	
Massage Therapy Total:						**228800.00**
Massage Therapy	Hour	220	26.00	40.00	**228800.00**	
Pain and Symptom						

Management Total:						**228800.00**
Pain and Symptom Management	Hour	220	26.00	40.00	**228800.00**	
Respite Total:						**370000.00**
Respite	Day	370	4.00	250.00	**370000.00**	
				GRAND TOTAL:		**27402960.00**
				Total Estimated Unduplicated Participants:		**3698**
				Factor D (Divide total by number of participants):		**7410.00**
				Average Length of Stay on the Waiver:		322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**20304960.00**
Case Management	Hour	3254	78.00	80.00	**20304960.00**	
Bereavement Services Total:						**457600.00**
Bereavement Services	Hour	220	52.00	40.00	**457600.00**	
Expressive Therapies Total:						**457600.00**
Expressive Therapies	Hour	220	52.00	40.00	**457600.00**	
Family Palliative Care Education (Training) Total:						**915200.00**
Family Palliative Care Education (Training)	Hour	220	104.00	40.00	**915200.00**	
Home and Vehicle Modification Total:						**4440000.00**
Home and Vehicle Modification	Project	370	1.00	12000.00	**4440000.00**	
Massage Therapy Total:						**228800.00**
Massage Therapy	Hour	220	26.00	40.00	**228800.00**	
Pain and Symptom Management Total:						**228800.00**
Pain and Symptom Management	Hour	220	26.00	40.00	**228800.00**	
Respite Total:						**370000.00**

Respite	Day	370	4.00	250.00	**370000.00**	

GRAND TOTAL:	**27402960.00**
Total Estimated Unduplicated Participants:	**3698**
Factor D (Divide total by number of participants):	**7410.00**
Average Length of Stay on the Waiver:	322